DWO For Mastectomy Products and Compression Garments

Fax completed DWO along with Patient Demographics and Medical Notes to (207) 425-1036

Therapy Shoppe, LLC
DME clinic
93 Main St
Mars Hill, ME 04758

Phone: (207) 810-4579
Fax: (207) 425-1036

www.therapyshoppeme.com

Date of Order: _____

Patient Information:

First Name: _____ Last Name: _____ DOB: _____
Patient Address: _____ City: _____ State: ___ Zip: _____
Phone: _____ Emergency Contact: _____ Phone: _____
Insurance: _____ Policy #: _____

Referring Clinic Information:

Clinic Name: _____ Therapist Name: _____
Clinic Address: _____ City: _____ State: ___ Zip: _____
Phone: _____ Fax: _____

Products Prescribed: Record number of items/pairs/refills
☐ Ready to wear ☐ Custom # of items ordered _____ # of refills _____ (Typically insurance covers 3 items/6 months)

Gradient Compression Level
☐ 15-20 mmHg ☐ 20-30 mmHg ☐ 30-40 mmHg ☐ 50+ mmHg ☐ Custom: _____ mmHg

Style Garments:
☐ Knee High ☐ Thigh High ☐ Waist High ☐ Maternity/Plus ☐ Burn Garments_____
☐ Arm Sleeve ☐ Gauntlet ☐ Glove ☐ Open Toe ☐ Full Foot ☐ Silicone Band width_____ cm
☐ Right ☐ Left ☐ Both ☐ Right leg chap ☐ Left leg chap

☐ Mastectomy Bras ☐ Torso Compression Garment ☐ Post-Op Camisole (Usually 3 items per 6 months)
☐ Breast Prosthesis, Silicone ☐ Left ☐ Right ☐ Both (typically insurance will cover 1 silicone prosthesis per breast per 2 years)
☐ Breast Prosthesis, Non-Silicone ☐ Left ☐ Right ☐ Both (typically insurance will cover 1 non-silicone prosthesis per 6 months)
☐ Nipple prosthetic #_____ (Usually 1 per prosthetic every 3 months)

Additional items requested: _____

Diagnosis: Primary ICD10 Code: _____ **Secondary ICD10 Code:** _____

Physician Information:
By signing and dating below, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) are both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.

Date of Last Face to Face: _____

Physician Name: _____ NPI #_____ Phone _____ Fax_____

Physician Signature: _____ **Date Signed**: _____

Physician Address _____ City _____ State ___ Zip _____

 Last updated 09/17/2025